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1600 MANAGING INAPPROPRIATE BEHAVIORS

1601 Overview

This chapter outlines requirements for developing and implementing effective strategies which address behavioral intervention and management of specific individual behavior considered to be inappropriate. In this context, "inappropriate" means to significantly interfere with, prevent or deny individual opportunities for community integration and full inclusion; to be at risk to an individual's own health and safety and/or, to be at risk to the health and safety of others.

Addressed in this chapter are the related definitions, applicability, emergency measures, programmatic functions and responsibilities of Individual Support Plan (ISP) teams, training, Human Rights Committees (HRC), Program Review Committees (PRC) including HRC's prohibitions related to behavioral programming, abuse, and neglect, behavior interventions and treatment plans.

1602 Definition and Applicability

"Managing Inappropriate Behavior" is the title of A.A.C. R6-6-901 or Article 9, as it is most commonly referred to. This article governs the DES/DDD's administration of a comprehensive State wide system for behavioral interventions and establishes the structure for developing, approving, implementing and monitoring of these plans.

All programs operated, licensed, certified, supervised or financially supported by the DES/DDD must comply with these policies and procedures. If the need to reduce inappropriate behaviors is identified, the ISP team must determine whether a behavioral intervention plan is needed. Behavioral intervention plans which include any of the interventions outlined in Section 1606.1 must be approved by the PRC and reviewed by the HRC.

A.R.S. § 36-551
A.A.C. R6-6-901

1603 Prohibitions

State statute prohibits abusive treatment or neglect of any individual with a developmental disability.

1603.1 Abuse

Prohibited abusive treatment, as it relates to managing inappropriate behavior, includes programmatic abuse, which uses an aversive stimuli technique that has not been approved as part of an individual's ISP, and which is not contained in the rules and regulations. This includes individual isolation.

Reference Chapter 2000 for more detailed information on abuse.

A.R.S. § 36-569(A); § 36-561(B)
A.A.C. R6-6-9

1603.2 Neglect

Prohibited neglectful treatment means any intentional failure to carry out a behavior treatment plan developed by the ISP team for an individual.

Chapter 2000 contains more detailed information regarding neglect.

A.R.S. § 36-569; § 36-561
A.A.C. R6-6-9

1603.3 Behavioral Intervention Techniques

Identified below are those techniques which are prohibited under the provisions of Article 9:

- a. use of locked time out rooms;
- b. use of over-correction; this means a group of procedures designed to reduce inappropriate behavior consisting of:

1. requiring an individual to restore the environment to a state vastly improved from that which existed prior to the inappropriate behavior; or
2. requiring an individual to repeatedly practice a behavior;
- c. application of noxious stimuli such as ammonia sprays or application of Tabasco sauce to the tongue;
- d. physical restraints, including mechanical restraints, when used as a negative consequence to a behavior;
- e. any other technique determined by the PRC to cause pain, severe discomfort, or severe emotional distress to the individual; and
- f. techniques addressed in A.R.S. § 36-561(A):
 1. psycho-surgery;
 2. insulin shock;
 3. electroshock; or
 4. experimental drugs.

A.R.S. § 36-561; § 36-551(A)
A.A.C. R6-6-9

1603.4 Behavior Modifying Medications

Except as indicated and specified in statute and rule, behavior modifying medications are prohibited if one of the following criteria are met:

- a. they are administered on an "as needed" or PRN basis;
- b. the ISP team determines that the dosage interferes with the individual's daily living activities; or
- c. they are used in the absence of a behavior treatment plan.

Section 1607 of this Chapter contains broader information regarding Behavior Modifying Medications.

A.R.S. § 36-561
A.A.C. R6-6-910

1603.5 **Treatment Plan Implementation**

No one shall implement a behavior treatment plan which:

- a. is not included as part of the ISP; and/or
- b. contains aversive behavior intervention techniques which do not have approval of the PRC and review by HRC.

A.R.S. § 36-561; § 36-569
A.A.C. R6-6-904(A)

1604 **Violations**

Any person violating the statutory provisions regarding the health and safety of persons with developmental disabilities, is guilty of a class two (2) misdemeanor.

A.R.S. § 36-569; § 36-561

1605 **Program Review Committee**

The Program Review Committee (PRC), is a specially constituted committee which meets to review for approval/disapproval, with recommended changes as necessary, any behavior treatment plan which meets the criteria set forth in Section 1606.1.

42 CFR 483.440(f)(3)
A.A.C. R6-6-904; R6-6-1701, et seq.

1605.1 Composition

The District Program Manager (DPM) is responsible for designating persons to serve on the PRC. This should minimally include:

- a. the DPM or designee as the chairperson;
- b. a person directly providing habilitation services;
- c. a person qualified, as determined by DES/DDD, who has experience in the use of behavior management techniques, such as a psychologist or psychiatrist;
- d. parent/guardian of a person with a developmental disability; but not the parent of the person whose program is being reviewed;
- e. persons with no ownership/controlling interest in a facility, and no involvement in service provision to persons with developmental disabilities; and
- f. a person with a developmental disability when appropriate.

A.A.C. R6-6-903(E)

1605.2 Responsibilities

The PRC must review and respond in writing within 10 working days of the receipt of a behavior treatment plan, either approving or disapproving the plan. The written response must be signed and dated by each member in attendance, forwarded to the ISP team and copied to the chair of the HRC. The written response shall include:

- a. a statement of agreement that the interventions approved are the least intrusive;
- b. that it is the least restrictive alternative;

- c. any special considerations/concerns, including specific monitoring instructions; and
- d. any recommendations for change, with explanations.

The PRC shall issue written reports to the DES/DDD Assistant Director summarizing its activities, findings/recommendations while maintaining the individual's confidentiality. Reports are required:

- a. monthly, to the designated DES/DDD staff, with a copy to the chairperson of the HRC; and
- b. annually, by December 31 of each calendar year, to the Assistant Director of DDD or designee, with a copy to the Developmental Disabilities Advisory Council.

A.A.C. R6-6-903

1606 Individual Support Plan Team

1606.1 Responsibilities

The ISP team must submit to the PRC and HRC committees any behavior treatment plan which includes:

- a. techniques that require the use of force;
- b. programs involving the use of response cost; this means a procedure often associated with token economies, designed to decrease inappropriate behaviors, in which reinforcers are taken away as a consequence of inappropriate behavior;
- c. programs which might infringe upon the rights of the individual;
- d. the use of behavior modifying medications; and
- e. protective devices used to prevent an individual from being injured due to self-injurious behavior.

Upon receipt of the response from the PRC, and as part of the plan development process, the ISP team must either:

- a. implement the approved behavior treatment plan;
- b. accept the PRC recommendation, and incorporate the revised behavior treatment plan into the ISP; or
- c. reject the PRC recommendation and develop a new behavior treatment plan.

All revised behavior treatment plans must be re-submitted to the PRC and the HRC for review and approval. No implementation shall occur prior to approval.

A.R.S. § 36-551(01)
A.A.C. R6-6-906

1607 Behavior Modifying Medications

Behavior modifying medications are those drugs which are prescribed, administered and directed specifically toward the reduction and eventual elimination of specific behaviors for which the drugs are prescribed.

Behavior modifying medications are only to be prescribed and used:

- a. as part of the individual's behavior treatment plan included in the ISP;
- b. when in the opinion of a licensed physician, they are deemed to be effective in producing an increase in appropriate behaviors or a decrease in inappropriate behaviors; and
- c. it can be justified by the prescribing physician that the harmful effects of the behavior clearly outweigh the potential negative effects of the medication, such as Tardive Dyskinesia. This effect is characterized by slow rhythmic, automatic, stereotyped movement, either generalized or in single muscle groups, which occur as an undesired, involuntary effect of therapy with certain psychotropic medications such as Haldol, Mellaril, Serentil and Navane.

The use of behavior modifying medications requires DES/DDD to make available the services of a consulting psychiatrist to review medical records and make recommendations to the prescribing physician which ensures the prescribed medication is the most appropriate in type/dosage to meet the needs of the individual.

The DES/DDD must provide monitoring of all behavior treatment plans which include the use of behavior modifying medications to:

- a. ensure that data collected regarding an individual's response to the medication is evaluated at least quarterly at a medication review by the physician and a member of the ISP team, other than the direct care staff responsible for implementing the approved behavior treatment plan;
- b. ensure that each individual receiving a behavior modifying medication is screened for side effects and Tardive Dyskinesia as needed, and that the results of such screening are:
 1. documented in the individual's central case record;
 2. provided immediately to the physician, individual/responsible person and ISP team for appropriate action in the event of positive screening results for side effects/Tardive Dyskinesia; and
 3. provided to the PRC/HRC and the DES/DDD Medical Director within 15 working days for review of the positive screening results.

The individual/responsible person must give informed, written consent before behavior modifying medications can be administered (Appendix 1500.D).

See Chapter 1500 for more detailed information regarding informed consent and the related forms.

A.A.C. R6-6-906; R6-6-909; R6-6-910

1608 Monitoring Behavior Modifying Medications/Treatment Plans

DES/DDD must provide the following monitoring for all behavior treatment plans which include the use of behavior modifying medications:

- a. second level reviews by a consulting psychiatrist to provide recommendations to the prescribing physician which ensure that the prescribed medication is the most appropriate, in type and dosage to meet the individual's needs;
- b. ensure that data collected regarding an individual's response to the medication is evaluated at least quarterly, at a medication review by the physician and the member of the ISP team designated pursuant to A.A.C. R6-6-906 and other members of the ISP team as needed;
- c. ensure that each individual receiving a behavior modifying medication is screened for side effects, and Tardive Dyskinesia as needed, and that the results of such screening are:
 1. documented in the individual's case record;
 2. provided immediately to the physician, individual, responsible person, and ISP team for appropriate action in the event of positive screening results; and
 3. provided to the PRC/HRC within 15 working days for review of positive screening results.

In the event of an emergency, a physician's order for a behavior modifying medication may, if appropriate, be requested for a specific one time emergency use. The person administering the medication shall immediately report it to the Support Coordinator, responsible person and any applicable DES/DDD designee. The responsible person shall immediately be notified of any changes in medication type or dosage.

A.A.C. R6-6-906; R6-6-909(B); R6-6-910

1609 Emergency Measures

When an emergency measure, including the use of behavior modifying medications is employed to manage a sudden, intense, out-of-control behavior, the person employing the measure must:

- a. report the circumstances immediately to the person designated by DES/DDD, the responsible person and the Support Coordinator (see Chapter 2100);
- b. within 1 day, provide a written report of the circumstances of the emergency measure to the responsible person, the Support Coordinator, the PRC/HRC chairpersons; and
- c. request that the Support Coordinator reconvene the ISP team to determine the need for a new or revised behavior treatment plan when any emergency measure is used two or more times within a 30 day period or with an identifiable pattern.

Subsequent to reconvening the ISP team, the Support Coordinator is responsible for documenting in the individual's case record the outcome of the ISP meeting.

Upon receipt of a written report as specified above, the PRC must:

- a. review, evaluate and track reports of emergency measures taken; and
- b. report, on a case by case basis, instances of excessive or inappropriate use of emergency measures for corrective action, to a person designated by DES/DDD.

A.A.C. R6-6-910(D)

1610 Physical Management Techniques

Client Intervention Training (C.I.T.) establishes specific techniques to be employed by staff and providers during an emergency to manage a sudden, intense, out-of-control behavior. The techniques can only be used by persons trained in C.I.T. who are certified by the trainer. Such physical management techniques must:

- a. use the least amount of intervention necessary to safely manage an individual;
- b. be used **only** when less restrictive methods were unsuccessful or are inappropriate;
- c. be used only when necessary to prevent the individual from harming himself/herself or others or causing severe property damage;
- d. be used concurrently with the uncontrolled behavior;
- e. be continued for the least amount of time necessary to bring the individual's behavior under control; and
- f. be appropriate to the situation to insure safety.

1610.1 Follow-up

Persons certified in C.I.T. may be re-certified if their supervisor determines that there is a need for re-training. This re-training can be accomplished by:

- a. viewing the video tape of the techniques, passing a written test and demonstrating the techniques to the satisfaction of an instructor; or
- b. attending the entire C.I.T. course again.

A.A.C. R6-6-907; R6-6-909; R6-6-910